Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

BAYLOR SURGICAL HOSPITAL AT FORT WORTH
750 12TH AVE
FORT WORTH TX 76104-2517

Respondent Name
TWIN CITY FIRE INSURANCE COMPANY

Carrier's Austin Representative Box
Box Number 47

MFDR Tracking Number
M4-10-4431-01

MFDR Date Received
June 21, 2010

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Requested reimbursement @ 200% of the Medicare allowable per TDI Rule 134.403. The Respondent underpaid charges and upon reconsideration upheld the original decision. Charges remain underpaid."

Amount in Dispute: $2,109.76

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The provider is claiming that they are due additional for CPT Code 29824… This procedure was denied pursuant to the lack of documentation… The carrier has discounted the procedures based on Medicare and Texas Guidelines. Given these rates deemed fair and reasonable under Division rules, the hospital's assertion that it is entitled to an additional $2,109.76 is not credible."

Response Submitted by: Twin City Fire Insurance Co., 300 S. State Street, Syracuse, New York 13202

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
January 29, 2010	Outpatient Hospital Services	$2,109.76	$2,022.57

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403, titled *Hospital Facility Fee Guideline – Outpatient*, sets out the reimbursement guidelines for facility services provided in an outpatient acute care hospital.
3. 28 Texas Administrative Code §134.203, titled *Medical Fee Guideline for Professional Services*, sets out the reimbursement for guidelines for professional medical services.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

- 217 – THE CHARGES HAVE BEEN DISCOUNTED PER REVIEW BY QMEDTRIX'S BILLCHEK SERVICE. FOR QUESTIONS REGARDING THIS ADJUSTMENT, PLEASE CALL QMEDTRIX AT 1-800-833-1993.
- 45 – CHARGE EXCEEDS FEE SCHEDULE/MAX ALLOWABLE OR CONTRACTED/LEGISLATED FEE ARRANGEMENT REIMBURSEMENT FOR RESUBMITTED INVOICE HAS BEEN CONSIDERED. NO ADDITIONAL MONIES ARE BEING PAID AT THIS TIME. BILL HAS BEEN PAID ACCORDING TO PPO CONTRACT.

Issues

1. Are the disputed services subject to a contractual agreement between the parties to this dispute?
2. Did the respondent raise new denial reason or defenses that were not presented to the requestor prior to the date the request for medical dispute resolution (MDR) was filed with the Division?
3. Do the medical records support the disputed services as billed?
4. What is the applicable rule for determining reimbursement for the disputed services?
5. What is the recommended payment amount for the services in dispute?
6. Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier reduced or denied disputed services with reason codes 217 – "THE CHARGES HAVE BEEN DISCOUNTED PER REVIEW BY QMEDTRIX'S BILLCHEK SERVICE. FOR QUESTIONS REGARDING THIS ADJUSTMENT, PLEASE CALL QMEDTRIX AT 1-800-833-1993" and 45 – "CHARGE EXCEEDS FEE SCHEDULE/MAX ALLOWABLE OR CONTRACTED/LEGISLATED FEE ARRANGEMENT REIMBURSEMENT FOR RESUBMITTED INVOICE HAS BEEN CONSIDERED. NO ADDITIONAL MONIES ARE BEING PAID AT THIS TIME. BILL HAS BEEN PAID ACCORDING TO PPO CONTRACT." The requestor's request for reconsideration letter states "Please be advised we are not participating with Qmedtrix; any PPO discounts applied are inappropriate. Texas Labor Code §413.011(d-3) states that the Division may request copies of each contract under which fees are being paid, and goes on to state that the insurance carrier may be required to pay fees in accordance with the division's fee guidelines if the contract is not provided in a timely manner to the Division. On August 31, 2010, the Division requested a copy of the contract between the network and the health care provider. The respondent replied by facsimile transmission on September 14, 2010 that a PPO issue does not exist for this dispute. The respondent did not provided documentation of a contract. No documentation was found to support a contractual agreement between the parties to this dispute. The disputed services will therefore be reviewed per applicable Division rules and fee guidelines.
2. Texas Administrative Code §133.307(d)(2)(B) states that "The response shall address only those denial reasons presented to the requestor prior to the date the request for MDR was filed with the Division and the other party. Any new denial reasons or defenses raised shall not be considered in the review." The respondent's position statement asserts that "The CPT Code billed 29824… was not adequately documented. According to the medical record submitted the excision of the entire distal clavicle was not performed." The respondent further states "This procedure was denied pursuant to the lack of documentation…" Review of the submitted explanations of benefits finds that the insurance carrier did not deny services with any code signifying lack of documentation, nor was any documentation found to support that the carrier presented this denial reason to the requestor prior to the date the request for MDR was filed with the Division. The Division therefore concludes that the respondent has not met the requirements of §133.307(d)(2)(B). This insurance carrier's new denial reason is not supported. The disputed services will therefore be reviewed per applicable Division rules and fee guidelines.
3. Review of the submitted medical records finds that the health care provider has sufficiently documented the procedures performed, including arthroscopic acromioplasty of the right shoulder and right shoulder arthroscopic Mumford resection to the distal clavicle. The Division concludes that the medical records support the disputed services as billed.
4. This dispute relates to facility services performed in an outpatient hospital setting with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule. Per §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables. Review of the submitted documentation finds that separate reimbursement for implantables was not requested.

5. Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure code used, the supporting documentation and the other services that appear on the bill. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Payment for ancillary and supportive items and services, including services that are billed without procedure codes, is packaged into payment for the primary service. A full list of APCs is published annually in the OPPS final rules which are publicly available through the Centers for Medicare and Medicaid Services (CMS) website. Reimbursement for the disputed services is calculated as follows:

   - Procedure code 29826 has a status indicator of T, which denotes a significant procedure subject to multiple procedure discounting. The highest paying status T APC is paid at 100%; all others are paid at 50%. This procedure is paid at 100%. This service is classified under APC 0042, which, per OPPS Addendum A, has a payment rate of $3,290.60. This amount multiplied by 60% yields an unadjusted labor-related amount of $1,974.36. This amount multiplied by the annual wage index for this facility of 0.9578 yields an adjusted labor-related amount of $1,891.04. The non-labor related portion is 40% of the APC rate or $1,316.24. The sum of the labor and non-labor related amounts is $3,207.28. If the total cost for a service exceeds 1.75 times the OPPS payment and also exceeds the annual fixed-dollar threshold of $2,175, the outlier payment is 50% of the amount by which the cost exceeds 1.75 times the OPPS payment. Per the OPPS Facility-Specific Impacts file, CMS lists the cost-to-charge ratio for this provider as 0.198. This ratio multiplied by the billed charge of $7,538.00 yields a cost of $1,492.52. The total cost of all packaged items is allocated proportionately across all separately paid OPPS services based on the percentage of the total APC payment. The APC payment for this service of $3,207.28 divided by the sum of all APC payments is 76.54%. The sum of all packaged costs is $1,117.18. The allocated portion of packaged costs is $855.13. This amount added to the service cost yields a total cost of $2,347.65. The cost of this service exceeds the annual fixed-dollar threshold of $2,175. The amount by which the cost exceeds 1.75 times the OPPS payment is $0.00. The total APC payment for this service, including outliers and any multiple procedure discount, is $3,207.28. This amount multiplied by 200% yields a MAR of $6,414.56.
   - Procedure code 29824 has a status indicator of T, which denotes a significant procedure subject to multiple procedure discounting. The highest paying status T APC is paid at 100%; all others are paid at 50%. This procedure is paid at 50%. This service is classified under APC 0041, which, per OPPS Addendum A, has a payment rate of $2,016.77. This amount multiplied by 60% yields an unadjusted labor-related amount of $1,210.06. This amount multiplied by the annual wage index for this facility of 0.9578 yields an adjusted labor-related amount of $1,159.00. The non-labor related portion is 40% of the APC rate or $806.71. The sum of the labor and non-labor related amounts is $1,965.71. The cost of this service does not exceed the annual fixed-dollar threshold of $2,175. The outlier payment amount is $0. The total APC payment for this service, including outliers and any multiple procedure discount, is $982.85. This amount multiplied by 200% yields a MAR of $1,965.71.

6. The total recommended payment for the services in dispute is $8,380.27. This amount less the amount previously paid by the insurance carrier of $6,357.70 leaves an amount due to the requestor of $2,022.57. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $ $2,022.57.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $ $2,022.57, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Grayson Richardson Medical Fee Dispute Resolution Officer	May 24, 2012 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.